

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

5018

STATE FILE NUMBER

-63-021435

DO NOT WRITE
ON THIS SUB

AMENDED

1. PLACE OF DEATH
a. COUNTY **FILED MAY 17 1963**

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE **Missouri** b. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only)
OR TOWN **St. Louis 10.**

Length of stay in 1b
12 hours

c. CITY
OR TOWN **St. Louis 16.**

Inside Limits
Yes ☒ No ☐

c. FULL NAME OF DECEASED (If in hospital, give location)
HOSPITAL OR INSTITUTION **St. Louis Children's Hospital**

Inside Limits
Yes ☒ No ☐

d. STREET ADDRESS (If outside, give location)
3733 Delor

Reside on Farm
Yes ☐ No ☒

3. NAME OF DECEASED
(Type of print) First Middle Last

Robert Charles Cole

4. DATE
OF DEATH

Month Day Year

5 8 63

5. SEX

Male

6. COLOR OR RACE

White

7. Married ☐ Never Married ☒
Widowed ☐ Divorced ☐

8. DATE OF BIRTH

5-3-63

9. AGE (last birthday)

IF UNDER 1 YEAR IF UNDER 24 HR

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

none

10b. KIND OF BUSINESS OR INDUSTRY

none

11. BIRTHPLACE (City and state or country)

St. Louis 10, Mo

12. CITIZEN OF WHAT COUNTRY

U.S.A.

13a. FATHER'S NAME

Charles Eugene Cole

13b. MOTHER'S MAIDEN NAME

Ruth Klein

14. NAME OF HUSBAND OR WIFE

none

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

no

17. INFORMANT Address

E. Worthington 500 S. Kingshighway St. Louis, Mo.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

18a. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

CARDIAC FAILURE

DUE TO (b)

CONGENITAL HEART DEFECTS

DUE TO (c)

VENTRICULAR AND ATRIAL SEPTAL DEFECTS

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

ANOMALOUS VENOUS RETURN AND Bicuspid Aortic VALVE.

19. WAS AUTOPSY PERFORMED?
YES ☒ NO ☐

20a. ACCIDENT SUICIDE HOMICIDE

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART II of item 18.)

754-2

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from **5-7-63** to **5-8-63** and last saw her/him alive on **5-8-63**
Death occurred at **2:10 a.m.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title)

Francis M. Henderson M.D.

22b. ADDRESS

500 S. Kingshighway

22c. DATE SIGNED

5/8/63

23a. BURIAL, CREMATION, REMOVAL (Specify)

REMOVAL

23b. DATE

MAY 9, 1963

23c. NAME OF CEMETERY OR CREMATORY

VAL HALLA Cem.

23d. LOCATION (City, town, or county)

ST. LOUIS Co Mo

24. FUNERAL DIRECTOR

Thomas Rutis 2906 Charois

25. DATE RECD. BY LOCAL REG.

MAY 9 1963

26. REGISTRAR'S SIGNATURE

Joan Smith, M.D.

USE BLACK INK

OR

TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

INSTEAD OF

DATE AMENDED

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

OK Helen L. Taylor No. 63-84-0

84

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed NOT
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Eleanor Province

Licensed Embalmer No.

3403

P. O. Address

2906 Jerni

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.